MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

COMPANION GUIDE FOR THE HIPAA 278 HEALTH CARE SERVICES REVIEW – REQUEST FOR REVIEW & RESPONSE, VERSION 4010A1

July 23, 2003
Revised October 9, 2003

Michigan Department of Community Health
MDCH

MSA
MEDICAL SERVICES ADMINISTRATION

Foreword

This document is intended as a companion to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Services Review – Request For Review and Response Addenda (004010X094A1)**, dated October 2002, and the original **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Services Review – Request For Review and Response (004010X094)**, dated May 2000. It follows guidelines authorized by the Department of Health and Human Services on September 17, 2001. This document should be used in conjunction with all MDCH guidelines. The clarifications described herein include:

- identifiers to use when a national standard has not been adopted [and]
- parameters in the implementation guide that provide options.

(The Addenda implementation guide can be found at http://www.wpc-edi.com/hipaa/hipaa_40.asp. HHS guidance on companion documents can be found at http://aspe.os.dhhs.gov/admnsimp/q0321.htm)

NOTE: ***Page references*** from the Implementation Guides refer to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Services Review – Request For Review and Response (004010X094)** ("Version 4010"), unless otherwise noted (with an asterisk (*)) as referring to the Addenda Implementation Guide ("Version 4010A1"), **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Services Review – Request For Review and Response Addenda (004010X094A1)**.

This document addresses the completion of segments and data elements as they pertain to all service types and the following specialty service types:

- Ambulance
- Chiropractic (Spinal Manipulation)
- Dental
- DME, Medical Supplies, Hearing Aid, Cochlear Implant Repair/Parts Replacement, Orthotics, and Prosthetics
- Long Term Care Nursing Facility (Complex)
- Oxygen
- Physician Services
- Preadmission authorization (MPRO)
- Therapy (Occupational, Physical, Speech)

Refer to the All Service Types section combined with the applicable specialty service type section to obtain information regarding the specific 278 Health Care Services Request segments and data elements necessary to process your request.

The 278 Health Care Services Request and Response transactions do not replace the verbal request process. If there is an urgent/emergent situation, telephone authorization must still be obtained.

October 8, 2003, Revisions

October 8, 2003, revisions to the Companion Guide for the HIPAA 278 Health Care Services Review – Request fro Review and Response, Version 4010A1, originally issued July 23, 2003, include changes related to the reporting of tooth number and tooth surface information. The revisions affect the following sections of this document:

- Loop 2000F HI01 through HI12-2 – Code List Qualifier Code (HIPAA IG p. 160; this guide p. 12)
- Loop 2000F MSG01 – Free-form Message Text (HIPAA IG p. 211; this guide p. 13)
- Tooth Surface Code(s) Communication Guidelines (App. B of this companion guide, pp. 40-41)

In addition, some minor formatting and editorial changes have been made.

Transaction Details

- MDCH accommodates the 278 Health Care Services transactions for the processing of prior authorizations. As noted in the X12N 278 (004010X094) Implementation Guide, the Michigan Department of Community Health (MDCH) will support one patient event (prior authorization request or preadmission certification request) per 278 transaction (ST through SE.)

- MDCH has made special arrangements to assist Michigan Peer Review Organization (MPRO) for the interchange of preadmission certification 278 Health Care Services Request and Response transactions. 278 Health Care Service Requests for preadmission certification received by MDCH will be forwarded to MPRO for processing. MPRO will return the corresponding preadmission certification 278 Health Care Service Responses to MDCH for forwarding back to the requesting entity.

- When using the 278 Health Care Services Request transaction, the following Michigan Department of Community Health (MDCH) forms do not need to be submitted:

    - Special Services Prior Approval-Request Authorization (MSA-1653-B)
    - Occupational/Physical Therapy-Speech Pathology Prior Approval-Request/Authorization (MSA-115)
    - Dental Prior Approval Authorization Request (MSA-16780-B)

  The 278 Health Care Services Request and Response transactions supply the same information noted on these forms. Any forms not noted must still be mailed and/or faxed.

- The 278 Health Care Services Request and Response transactions do not support the ability to submit all supporting documentation electronically. To process a 278 Health Care Services Request properly, the requester will still be required to mail or fax (when applicable) the necessary supporting documentation.

- To correlate an electronically submitted prior authorization request properly with mailed or faxed supporting documentation, MDCH requires the use of a trace number located in the TRN segment of

Loop 2000C.[1] This trace number must be a unique number for each individual prior authorization or preadmission certification request. The trace number submitted on the electronic request must be noted on all mailed or faxed supporting documentation. Failure to place the trace number in the 278 Request and on all mailed or faxed documentation may result in the rejection or denial of the prior authorization or preadmission certification request.

- MDCH will return a 997 Acknowledgement when a 278 Request for Review transaction is accepted for processing or when syntactical errors are encountered. When errors are encountered within the interchange, a TA1 transaction will be produced and no Functional Groups within the Interchange will be processed.

- When a 278 Health Care Service Request for prior authorization is accepted for processing, MDCH will generate a 278 Health Care Service Response within fifteen (15) business days.

- MPRO will generate a 278 Health Care Service Response for an accepted 278 Health Care Service Request for preadmission certification within one (1) business day.

- When the 278 Request for Review transaction has missing or invalid data, the electronic request for prior authorization or preadmission certification will be rejected resulting in a 278 Health Care Service Response transaction with applicable AAA segment(s). The AAA segments provide explanation of the error(s) found and, in most instances, will require correction and resubmission of the request. Refer to the Transaction Error Explanation section of this document for further information.

- MDCH may return a 278 Response transaction requesting additional information. The request for additional information will specify where the additional information should be mailed or faxed. If MDCH does not receive the requested information within thirty business days, another 278 Response transaction will be returned denying the electronically submitted prior authorization request.

- MPRO will request all additional information via the telephone. If MPRO does not receive the requested additional information within three (3) business days, a 278 Response transaction will be returned denying the preadmission certification request.

- The X12N 278 version 4010 and the Addenda version 4010A1 do not readily support the communication of procedure modifier(s), tooth number(s), and tooth surface code(s). MDCH does require these data elements in most instances in order to properly process prior authorization requests. Please refer to Appendix A for the Modifier Communication Guidelines and Appendix B for the Tooth Surface Code(s) Communication Guidelines.

[1] Refer to the October 2002 Addenda (X12N 278 004010X094A1).

Interchange Control Header

Page*	Loop	Segment	Data Element	Comments
B.4	Interchange	ISA – Interchange Control Header	ISA05 – Interchange ID Qualifier	Use "ZZ".
B.4	Interchange	ISA – Interchange Control Header	ISA06 – Interchange Sender ID	278 Request transaction – Use the 4-character MDCH assigned Billing Agent ID. 278 Response transaction – "D00111" (MDCH) will be returned.
B.5	Interchange	ISA – Interchange Control Header	ISA07 – Interchange ID Qualifier	Report "ZZ".
B.5	Interchange	ISA – Interchange Control Header	ISA08 – Interchange Receiver ID	278 Request transaction – Use "D00111" for MDCH. 278 Response transaction – The 4-character MDCH-assigned Billing Agent ID will be returned.

Functional Group Header

Page	Loop	Segment	Data Element	Comments
B.8	Functional Group	GS – Functional Group Header	GS02 – Application Sender's Code	278 Request transaction – Use the 4-character MDCH-assigned Billing Agent ID. 278 Response transaction – Value will be "D00111" when MDCH is responding. Value will be "MPRO" when MPRO is responding.
B.8	Functional Group	GS – Functional Group Header	GS03 – Application Receiver's Code	278 Request transaction – Use "D00111" when the Functional Group contains a prior authorization request for MDCH. Use "MPRO" when the Functional Group contains a preadmission certification request for MPRO. 278 Response transaction – The 4-character MDCH-assigned Billing Agent ID will be returned.
235*	Functional Group	GS – Functional Group Header	GS08 – Version / Release / Industry Identifier Code	Use "004010X094A1".

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

278 Request for Review Transaction Data Elements

All Service Types

The following table provides MDCH supplemental information for all service types. Please also refer to the applicable prior authorization service type section or preadmission certification (MPRO) section to ensure that your 278 Health Care Services Request transaction contains the necessary data for processing.

Page*	Loop	Segment	Data Element	Comments
56	2010A – Utilization Management Organization (UMO) Name	NM1 – Utilization Management Organization (UMO) Name	NM103 – UMO Last or Organization Name	Use “Department of Community Health” for MDCH prior authorization requests. Use “MPRO” for MPRO preadmission certification requests.
57	2010A – Utilization Management Organization (UMO) Name	NM1 – Utilization Management Organization (UMO) Name	NM108 – Identification Code Qualifier	Use “PI” (Payer ID) for MDCH prior authorization requests. Use “24” (Employer Identification Number) for MPRO preadmission certification requests.
57	2010A – Utilization Management Organization (UMO) Name	NM1 – Utilization Management Organization (UMO) Name	NM109 – UMO Identifier	Use “D00111” for MDCH. Use “'382536610” for MPRO.
64	2010B – Requester Name	REF – Requester Supplemental Identification	REF01 – Reference Identification Qualifier	Required by MDCH and MPRO. Use “ZH” (Carrier Assigned Reference Number).
64	2010B – Requester Name	REF – Requester Supplemental Identification	REF02 – Requester Supplemental Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by the 7-digit provider identification number).
65	2010B – Requester Name	N3 – Requester Address	N301 –Requester Address Line	Specify the address that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010B.
66	2010B – Requester Name	N4 – Requester City/State/Zip Code	N401 – Requester City Name	Specify the city name that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010B.
67	2010B – Requester Name	N4 – Requester City/State/Zip Code	N402 – Requester State or Province Code	Specify the state or province code that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010B.
67	2010B – Requester Name	N4 – Requester City/State/Zip Code	N403 – Requester Zip Code	Specify the zip code that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010B.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
67	2010B – Requester Name	N4 – Requester City/State/Zip Code	N404 – Requester Country Code	When the location that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010B is not within the United States, specify the applicable country code (e.g., Canada)
69	2010B – Requester Name	PER – Requester Contact Information	PER02 – Requester Contact Name	This identifies the person MDCH or MPRO should contact for any needed additional information. If the Requester Contact Name and the Requester name are the same, do not submit a Requester Contact Name.
69	2010B – Requester Name	PER – Requester Contact Information	PER03 – Communication Number Qualifier	Use “TE” (Telephone) or “FX” (Facsimile).
69	2010B – Requester Name	PER – Requester Contact Information	PER04 – Requester Contact Communication Number	Use the corresponding communication number in the applicable format. (The format is AAABBBCCCC, where AAA = Area code, BBB = telephone number prefix, CCCC = telephone number; for example, 517-555-1234 would be 5175551234).
70	2010B – Requester Name	PER – Requester Contact Information	PER05 or PER07 – Communication Number Qualifier	Use “TE” (Telephone) or “EX” (Telephone Extension), or “FX” (Facsimile).
70	2010B – Requester Name	PER – Requester Contact Information	PER06 or PER08 – Requester Contact Communication Number	Specify the telephone number for the Provider Contact Name in the applicable format (e.g., AAABBBCCCC; where AAA = Area code, BBB = telephone number prefix, CCCC = telephone number; therefore 517-555-1234 would be 5175551234.)
71	2010B – Requester Name	PRV – Requester Provider Information	PRV01 – Provider Code	When the requesting entity is not the same as the servicing provider, specify the requesting provider’s role using the applicable PRV01 Provider Code.
37*	2000C – Subscriber Level	TRN – Patient Event Tracking Number	TRN02 – Patient Event Tracking Number	A requester-assigned tracking number is required for each prior authorization or preadmission certification request. The assigned tracking number must also be present on any faxed or mailed supporting documentation. This is a unique number assigned to each individual patient prior authorization/preadmission certification request. Failure to report this information electronically and on the corresponding documentation could result in the rejection or denial of your request.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
81	2000C – Subscriber Level	HI – Subscriber Diagnosis	HI01-2, HI02-2, HI03-2 and HI04-2 – Diagnosis Code	Prior authorization and preadmission certification requests are required to include the supporting ICD-9-CM codes for all service types, excluding dental services (unless they are CSHCS [Title V] orthodontic services) or Long Term Care Nursing Facility (complex). Currently the first four (4) ICD-9-CM codes per 278 Health Care Service Request submitted are used.
42-43*	2000C – Subscriber Level	PWK – Additional Patient Information	PWK02 – Attachment Transmission Code	Use only one of the following: "AA" (Available on Request at Provider Site); "BM" (By Mail); or "FX" (By Fax).
42-43*	2000C – Subscriber Level	PWK – Additional Patient Information	PWK06 – Attachment Control Number	When using "BM" or "FX" in PWK02, use the same number reflected as the Patient Event Tracking Number in Loop 2000C TRN02.
90	2010CA – Subscriber Name	NM1 – Subscriber Name	NM108 – Subscriber ID Code Qualifier	Use "MI" (Member ID = Recipient ID).
91	2010CA – Subscriber Name	NM1 – Subscriber Name	NM109 – Subscriber Identifier	Use the MDCH recipient 8-digit identification number.
94	2010CA – Subscriber Name	DMG – Subscriber Demographic Information	DMG02 – Subscriber Date of Birth	Required by MDCH and MPRO. Use the recipient's date of birth.
94	2010CA – Subscriber Name	DMG – Subscriber Demographic Information	DMG03 – Subscriber Gender Code	Required by MDCH and MPRO. Use the recipient's gender.
127	2010E – Service Provider Name	REF – Service Provider Supplemental Identification	REF01 – Reference Identification Qualifier	Required by MDCH and MPRO. Use "ZH" (Carrier Assigned Reference Number).
128	2010E – Service Provider Name	REF – Service Provider Supplemental Identification	REF02 – Service Provider Supplemental Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by the 7-digit provider identification number)
129	2010E – Service Provider Name	N3 – Requester Address	N301 – Requester Address Line	Specify the address that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.
130	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N401 – Requester City Name	Specify the city name that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.

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Page*	Loop	Segment	Data Element	Comments
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N402 – Requester State or Province Code	Specify the state or province code that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N403 – Requester Zip Code	Specify the zip code that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N404 – Requester Country Code	When the location that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E is not within the United States, specify the applicable country code (e.g., Canada).
133	2010E – Service Provider Name	PER – Service Provider Contact Information	PER02 – Service Provider Contact Name	If the service provider is not the requester and the information is available, provide a contact name for the service provider. If the service provider Contact Name and the service provider Name are the same, do not submit a Service Provider Contact Name.
133	2010E – Service Provider Name	PER – Requester Contact Information	PER03 – Communication Number Qualifier	Use “TE” (Telephone) or “FX” (Facsimile).
133	2010E – Service Provider Name	PER – Requester Contact Information	PER04 – Requester Contact Communication Number	Specify the telephone number for the Provider Contact Name in the applicable format (e.g., AAABBBCCCC; where AAA = Area code, BBB = telephone number prefix, CCCC = telephone number; therefore 517-555-1234 would be 5175551234.)
133	2010E – Service Provider Name	PER – Requester Contact Information	PER05 or PER07 – Communication Number Qualifier	Use “TE” (Telephone) or “EX” (Telephone Extension), or “FX” (Facsimile).
134	2010E – Service Provider Name	PER – Requester Contact Information	PER06 or PER08 – Requester Contact Communication Number	Specify the telephone number for the Provider Contact Name in the applicable format (e.g., AAABBBCCCC; where AAA = Area code, BBB = telephone number prefix, CCCC = telephone number; therefore 517-555-1234 would be 5175551234.)
134	2010E – Service Provider Name	PRV – Requester Provider Information	PRV01 – Provider Code	When the Service Provider entity is not the same as the Requester, specify the Service Provider’s role using the applicable PRV01 Provider Code.
141	2000F – Service Level	UM – Health Care Services Review Information	UM01 – Request Category Code	Use “AR” (Admission Review) for MPRO preadmission certification requests. Use “HS” (Health Services Review) for MDCH prior authorization requests.

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Page*	Loop	Segment	Data Element	Comments
142	2000F – Service Level	UM – Health Care Services Review Information	UM02 - Certification Type Code	Applicable values for MDCH or MPRO requests are: “I” (Initial) “4” (Extension) “R” (Renewal) “S” (Revised)
142	2000F – Service Level	UM – Health Care Services Review Information	UM03 – Service Type Code	Refer to the applicable Service Type section to identify the appropriate code.
146	2000F – Service Level	UM –Health Care Services Review Information	UM04-1 – Facility Type Code	Refer to the applicable Service Type section to identify the appropriate code.
146	2000F – Service Level	UM –Health Care Services Review Information	UM04-2 – Facility Code Qualifier	Refer to the applicable Service Type section to identify the appropriate code.
150	2000F – Service Level	REF – Previous Identification Number	REF02 – Previous Identification Number	Required when Loop 2000F UM02 = “R” or “4”. Use the previously assigned prior authorization or PACE number.
159	2000F – Service Level	HI – Procedures		MDCH and MPRO require the submission of this segment for all prior authorization or preadmission certification requests. Refer to the applicable Service Type section for specific data element information.
102-103*	2000F – Service Level	PWK – Additional Service Information	PWK02 – Attachment Transmission Code	Use only one of the following: “AA” (Available on Request at Provider Site) “BM” (By Mail) “FX” (By Fax)
102-103*	2000F – Service Level	PWK – Additional Service Information	PWK06 – Attachment Control Number	When using “BM” or “FX” in PWK02, use the Patient Event Tracking Number utilized in Loop 2000C TRN02 in PWK06.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Ambulance Service Type

Submission of a 278 Health Care Services Request for these service types still requires the mailing of supporting documentation. Submit supporting documentation to the following address or via the noted fax number:

Medical Services Administration
Special Services-Prior authorization
PO Box 30170
Lansing, MI 48909

Fax number: 1-517-241-0740

The trace number submitted on the electronic request (Loop 2000C TRN02) must be noted on all mailed or faxed supporting documentation. This must be a unique number assigned to each individual patient/beneficiary prior authorization request. Failure to place the trace number on all mailed or faxed documentation may result in the rejection or denial of your prior authorization or preadmission certification request.

The communication of procedure modifiers (origination and destination) is not readily supported in the X12N 278 Version 4010. Please refer to Appendix A for the Modifier Communication Guidelines.

In addition to the following information, please refer to the 278 Request for Review Companion document – All Service Types section.

Page*	Loop	Segment	Data Element	Comments
141	2000F – Service Level	UM –Health Care Services Review Information	UM01 – Request Category Code	Use “HS” (Health Services Review).
142	2000F – Service Level	UM –Health Care Services Review Information	UM03 – Service Type Code	Use “59” (Licensed Ambulance).
146	2000F – Service Level	UM –Health Care Services Review Information	UM04-1 – Facility Type Code	Identifies the destination facility type. Refer to Loop 2000F UM04-2 for code information.
146	2000F – Service Level	UM –Health Care Services Review Information	UM04-2 – Facility Code Qualifier	Use “B” (Place of Service code used in 837P CLM05-1) and list the applicable place of service code in UM04-1.
159	2000F – Service Level	HI – Procedures	HI01-1 through HI12-2 – Code List Qualifier Code	Use “BO” (CPT-4 or HCPCS code).

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Page*	Loop	Segment	Data Element	Comments
180	2000F – Service Level	CRC – Patient Condition Information		Use this segment to provide any additional information regarding the patient's condition.
191	2000F – Service Level	CR1 – Ambulance Transport Information	CR105 – Unit or Basis for Measurement Code	Required by MDCH. Use "DH" (Miles).
192	2000F – Service Level	CR1 – Ambulance Transport Information	CR106 – Transport Distance	Required by MDCH. Use the number of miles recipient will be transported.
192	2000F – Service Level	CR1 – Ambulance Transport Information	CR107 – Ambulance Trip Origin Address	Required by MDCH.
192	2000F – Service Level	CR1 – Ambulance Transport Information	CR108 – Ambulance Trip Destination Address	Required by MDCH.
211	2000F – Service Level	MSG – Message Text	MSG01 – Free-form Message Text	This data element is used to communicate procedure modifier (origination and destination codes) information and to communicate any additional service information not accommodated else where in the 278 Health Care Services Request transaction. Additional information is reported after the procedure modifier information and is preceded by the word "TEXT". Refer to Appendix A for further information.

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Chiropractic Service Type

Submission of a 278 Health Care Services Request for these service types still requires the mailing of supporting documentation. Submit supporting documentation to the following address or via the noted fax number:

Medical Services Administration
Special Services-Prior authorization
PO Box 30170
Lansing, MI 48909

Fax number: 1-517-335-0075

The trace number submitted on the electronic request (Loop 2000C TRN02) must be noted on all mailed or faxed supporting documentation. This must be a unique number assigned to each individual patient/beneficiary prior authorization request. Failure to place the trace number on all mailed or faxed documentation may result in the rejection or denial of your prior authorization or preadmission certification request.

The communication of procedure modifiers is not readily supported in the X12N 278 Version 4010. Please refer to Appendix A for the Modifier Communication Guidelines.

In addition to the following information, please refer to the 278 Request for Review Companion document – All Service Types section.

Page*	Loop	Segment	Data Element	Comments
78	2000C – Subscriber Level	DTP – Onset of Current Symptoms or Illness Date	DTP03 – Onset Date	MDCH requires the reporting of the first Subluxation visit date in the Onset Date data element.
141	2000F – Service Level	UM – Health Care Services Review Information	UM01 – Request Category Code	Use “HS” (Health Services Review).
142	2000F – Service Level	UM – Health Care Services Review Information	UM03 – Service Type Code	Use “33” (Chiropractic).
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-1 – Facility Type Code	Identifies the type of facility where services will be performed. Refer to Loop 2000F UM04-2 for code information.
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-2 – Facility Code Qualifier	Use “B” (Place of Service code used in 837P CLM05-1) and list the applicable place of service code in UM04-1.

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Page*	Loop	Segment	Data Element	Comments
159	2000F – Service Level	HI – Procedures	HI01-1 through HI12-2 – Code List Qualifier Code	Use “BO” (CPT-4 or HCPCS code).
160	2000F – Service Level	HI – Procedures	HI01-3 through HI12-3 – Date Time Period Format Qualifier	Use “RD8” (Format CCYYMMDD-CCYYMMDD).
160	2000F – Service Level	HI – Procedures	HI01-4 through HI12-4 – Procedure Date	MDCH requires the reporting of the scheduled begin service date (scheduled 19th visit) and the scheduled end service date (e.g., 20030801-20031231).
69*	2000F – Service Level	HI – Procedures	HI01-5 through HI12-5 – Procedure Monetary Amount	Use to report the per-visit charge.
180	2000F – Service Level	CRC – Patient Condition Information		Use this segment to provide any additional information regarding the patient’s condition.
194	2000F – Service Level	CR2 – Spinal Manipulation Service Information	CR201 – Treatment Series Number	Required by MDCH. Report the beginning treatment series number requested for authorization (e.g., “19”).
194	2000F – Service Level	CR2 – Spinal Manipulation Service Information	CR202 – Treatment Count	Required by MDCH. Report the total number of series treatments being requested for prior authorization.
211	2000F – Service Level	MSG – Message Text	MSG01 – Free-form Message Text	This data element is used to communicate procedure modifier information and to communicate any additional service information not accommodated elsewhere in the 278 Health Care Services Request transaction. Additional information is reported after procedure modifier information and is preceded by the word “TEXT”. Refer to Appendix A for further information.

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Dental Service Types

Submission of a 278 Health Care Services Request for these service types still requires the mailing of supporting documentation to the following address or via the noted fax number:

Medical Services Administration
Special Services-Prior authorization
PO Box 30170
Lansing, MI 48909

Fax number: 1-517-335-0075

The trace number submitted on the electronic request (Loop 2000C TRN02) must be noted on all mailed or faxed supporting documentation. This must be a unique number assigned to each individual patient/beneficiary prior authorization request. Failure to place the trace number on all mailed or faxed documentation may result in the rejection or denial of your prior authorization or preadmission certification request.

The communication of missing teeth, and tooth surface(s) is not readily supported in the X12N 278 Version 4010. The MSG segment in Loop 2000F is used for the reporting of tooth surface codes. Please refer to Appendix B for further information. The PWK segment in Loop 2000C is used for the reporting of missing teeth, as noted in the following table.

In addition to the following information, please refer to the 278 Request for Review Companion document – All Service Types section.

Page*	Loop	Segment	Data Element	Comments
42-43*	2000C – Subscriber Level	PWK – Additional Patient Information	PWK01 – Report Type Code	Use “P6” (Periodontal Charts) when reporting missing teeth.
42-43*	2000C – Subscriber Level	PWK – Additional Patient Information	PWK02 – Attachment Transmission Code	Use “AA” (Available on Request at Provider Site) when reporting missing teeth.
42-43*	2000C – Subscriber Level	PWK – Additional Patient Information	PWK07 – Attachment Description	Report all applicable missing teeth in PWK07. Each tooth number should be two positions. Single numbers should begin with a zero (e.g., “2” would be “02”) and alpha would be followed by a space (e.g., “A” would be “A ”.) There should be a space between each missing tooth number (e.g., 01 07 10 or A G M).

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Page*	Loop	Segment	Data Element	Comments
81	2000C – Subscriber Level	HI – Subscriber Diagnosis	HI01-2, HI02-2, HI03-2 and HI04-2 – Diagnosis Code	Only required when requesting prior authorization for CSHCS (Title V) orthodontic services. Submit the supporting ICD-9-CM codes as noted in Chapter III of the MSA Provider Services Manual. MDCH currently uses up to four (4) supporting ICD-9-CM codes per 278 Health Care Service Request transaction.
141	2000F – Service Level	UM – Health Care Services Review Information	UM01 – Request Category Code	Use “HS” (Health Services Review).
142	2000F – Service Level	UM – Health Care Services Review Information	UM03 – Service Type Code	Use one of the applicable codes: “24” (Periodontics) “26” (Endodontics) “27” (Maxillofacial Prosthetics) “35” (Dental Care) “36” (Dental Crown) “38” (Orthodontics) “39” (Prosthodontics)
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-1 – Facility Type Code	Identifies the type of facility where services will be performed. Refer to Loop 2000F UM04-2 for code information.
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-2 – Facility Code Qualifier	Use “B” (Place of Service code used in 837D CLM05-1) and list the applicable place of service code in UM04-1.
160	2000F – Service Level	HI – Procedures	HI01-1 through HI12-2 – Code List Qualifier Code	Use “B0” (CDT-3 code) “JP” (Tooth Number code) – This code is only used in conjunction with “B0” (CDT-3 code). The CDT-3 code that corresponds to the tooth number should always be reflected in the HI data element that precedes the tooth number data element. Refer to Appendix B for further information.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
211	2000F – Service Level	MSG – Message Text	MSG01 – Free-form Message Text	This data element is used to communicate tooth surface information and to communicate any additional service information not accommodated else where in the 278 Health Care Services Request transaction. Additional information is reported after applicable tooth surface information and is preceded by the word “TEXT”. Refer to Appendix B for further information.
175	2000F – Service Level	HSD – Health Care Services Delivery		MDCH requires the use of the HSD segment to specify the duration of need for Orthodontics prior authorization.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

DME, Medical Supplies, Hearing Aid, Cochlear Implant Repair/Parts Replacement, Orthotics, and Prosthetics Service Types

Submission of a 278 Health Care Services Request for these service types still requires the mailing of supporting documentation to the following address or via the noted fax number:

Medical Services Administration
Special Services-Prior authorization
PO Box 30170
Lansing, MI 48909

Fax number: 1-517-335-0075

The trace number submitted on the electronic request (Loop 2000C TRN02) must be noted on all mailed or faxed supporting documentation. This must be a unique number assigned to each individual patient/beneficiary prior authorization request. Failure to place the trace number on all mailed or faxed documentation may result in the rejection or denial of your prior authorization or preadmission certification request.

In addition to the following information, please refer to the 278 Request for Review Companion document – All Service Types section.

Page*	Loop	Segment	Data Element	Comments
141	2000F – Service Level	UM – Health Care Services Review Information	UM01 – Request Category Code	Use “HS” (Health Services Review).
142	2000F – Service Level	UM – Health Care Services Review Information	UM03 – Service Type Code	Use one of the applicable codes: “12” (DME Purchase - including Hearing aid and Cochlear implant repair/parts replacement) “14” (Renal supplies in the home) “16” (Chronic Renal Disease Equipment) “18” (DME Rental) “75” (Prosthetic Device) – MDCH will use this code as representation of Prosthetics and Orthotics until a standard code is created for Orthotics.
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-1 – Facility Type Code	Identifies the type of facility where services will be performed. Do not use when Service Type Code “14” is reported. Refer to Loop 2000F UM04-2 for code information.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-2 – Facility Code Qualifier	If the claim for payment will be submitted in the 837I format or on a UB-92 form, use "A" (Uniform Billing Claim Form Bill Type) and list the first and second position of the Uniform Bill Type Code in UM04-1. If the claim for payment will be submitted in the 837P or on a HCFA1500, use "B" (Place of Service code used in 837P CLM05-1) and list the applicable place of service code in UM04-1.
159	2000F – Service Level	HI – Procedures	HI01-1 through HI12-2 – Code List Qualifier Code	Use one of the following codes: "BO" (CPT-4 or HCPCS code) "ABR" (Revenue Code)[2]
175	2000F – Service Level	HSD – Health Care Services Delivery		MDCH requires the use of the HSD segment to communicate the pattern of delivery, duration of need, and/or usage information needed to process these service type requests.
180	2000F – Service Level	CRC – Patient Condition Information		Use this segment to provide any additional information regarding the patient's condition.
211	2000F – Service Level	MSG – Message Text	MSG01 – Free-form Message Text	This data element is used to communicate procedure modifier information and to communicate additional service information not accommodated else where in the 278 Health Care Services Request transaction. Additional information is reported after procedure modifier information and is preceded by the word "TEXT". Refer to Appendix A for further information.
121	2000E – Service Provider Level	HL – Hierarchical Level		MDCH requires the communication of ordering provider information for these service types. This is accommodated via a repeat of Loop 2000E, Loop 2010E, and their corresponding data elements. For further information regarding the transaction structure for identifying multiple providers, refer to page 31, Section 2.2.3.5, of the X12N 278 Version 4010 Implementation Guide.
125	2010E – Service Provider Name	NM1 – Service Provider Name	NM101 – Entity Identifier Code	Use "1T" (Physician, Clinic, or Group Practice).

[2] Addenda added, refer to page 68 of the October 2002 Addenda.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
127	2010E – Service Provider Name	REF – Service Provider Supplemental Identification	REF01 – Reference Identification Qualifier	Required by MDCH. Use “ZH” (Carrier Assigned Reference Number).
128	2010E – Service Provider Name	REF – Service Provider Supplemental Identification	REF02 – Service Provider Supplemental Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by the 7-digit provider identification number)
129	2010E – Service Provider Name	N3 – Requester Address	N301 – Requester Address Line	Specify the address that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.
130	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N401 – Requester City Name	Specify the city name that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N402 – Requester State or Province Code	Specify the state or province code that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N403 – Requester Zip Code	Specify the zip code that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N404 – Requester Country Code	When the location that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E is not within the United States, specify the applicable country code (e.g., Canada)
134	2010E – Service Provider Name	PRV – Requester Provider Information	PRV01 – Provider Code	Required for use by MDCH when Loop 2000E is repeated. Use “OR” (Ordering).

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Long Term Care Nursing Facility (Complex) Service Type

Submission of a 278 Health Care Services Request for these service types still requires the mailing or faxing of a completed Memorandum of Understanding (MOU) and any supporting documentation to the following mailing address or via the noted fax number:

Michigan Department of Community Health
Long Term Care Programs
P.O. Box 30479
Lansing, MI 48909

Fax number: 1-517-241-8995.

The trace number submitted on the electronic request (Loop 2000C TRN02) must be noted on all mailed or faxed supporting documentation. This must be a unique number assigned to each individual patient/beneficiary prior authorization request. Failure to place the trace number on all mailed or faxed documentation may result in the rejection or denial of your prior authorization or preadmission certification request.

In addition to the following information, please refer to the 278 Request for Review Companion document – All Service Types section.

Page*	Loop	Segment	Data Element	Comments
133	2010E – Service Provider Name	PER – Service Provider Contact Information	PER02 – Service Provider Contact Name	List the Provider Contact Name for the Nursing Facility.
133	2010E – Service Provider Name	PER – Requester Contact Information	PER03 – Communication Number Qualifier	Use “TE” (Telephone).
133	2010E – Service Provider Name	PER – Requester Contact Information	PER04 – Requester Contact Communication Number	Specify the telephone number for the Provider Contact Name in the applicable format (e.g., AAABBBCCCC; where AAA = Area code, BBB = telephone number prefix, CCCC = telephone number; therefore 517-555-1234 would be 5175551234.)
141	2000F – Service Level	UM – Health Care Services Review Information	UM01 – Request Category Code	Use “HS” (Health Services Review).
142	2000F – Service Level	UM – Health Care Services Review Information	UM03 – Service Type Code	Use “54” (Long Term Care).

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-1 – Facility Type Code	Identifies the type of facility where services will be rendered. List the first and second position of the Uniform Bill Type Code.
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-2 – Facility Code Qualifier	Use "A" (Uniform Billing Claim Form Bill Type).
154	2000F – Service Level	DTP – Admission Date	DTP03 – Proposed or Actual Admission Date	When applicable, report the corresponding admission date.
159	2000F – Service Level	HI – Procedures	HI01-1 through HI12-2 – Code List Qualifier Code	Use "ABR" (Revenue Code)[3].
69*	2000F – Service Level	HI – Procedures	HI01-5 through HI12-5 – Procedure Monetary Amount	Use to report the Total Daily MOU Rate.
160	2000F – Service Level	HI – Procedures	HI01-6 through HI12-6 – Procedure Quantity	Specify the Units – No. of Days.
175	2000F – Service Level	HSD – Health Care Services Delivery		MDCH requires the use of the HSD segment to communicate the Average Daily Excess Nursing Hours. Loop 2000F will need to be repeated in order to report hours applicable to RN, LPN, and Aide services.
206	2000F – Service Level	CR6 – Home Health Care Information		MDCH requires the use of the CR6 segment to communicate information regarding long term care.
206	2000F – Service Level	CR6 – Home Health Care Information	CR602 – Service From Date	Use the effective date of current CCMOU.
207	2000F – Service Level	CR6 – Home Health Care Information	CR604 – Certification Period	Use the start and end date.

[3] Addenda added, refer to page 68 of the October 2002 Addenda.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Oxygen Service Type

Submission of a 278 Health Care Services Request for these service types still requires the mailing of supporting documentation to the following address or via the noted fax number:

Medical Services Administration
Special Services-Prior authorization
PO Box 30170
Lansing, MI 48909

Fax number: 1-517-335-0075

The trace number submitted on the electronic request (Loop 2000C TRN02) must be noted on all mailed or faxed supporting documentation. This must be a unique number assigned to each individual patient/beneficiary prior authorization request. Failure to place the trace number on all mailed or faxed documentation may result in the rejection or denial of your prior authorization or preadmission certification request.

In addition to the following information, please refer to the 278 Request for Review Companion document – All Service Types section.

Page*	Loop	Segment	Data Element	Comments
141	2000F – Service Level	UM – Health Care Services Review Information	UM01 – Request Category Code	Use “HS” (Health Services Review).
142	2000F – Service Level	UM – Health Care Services Review Information	UM03 – Service Type Code	Use one of the applicable codes: “12” (DME Purchase) “18” (DME Rental)
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-1 – Facility Type Code	Identifies the type of facility where services will be rendered. List the applicable place of service code used in 837P CLM05-1.
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-2 – Facility Code Qualifier	Use “B” (Place of Service code used in 837P CLM05-1).
159	2000F – Service Level	HI – Procedures	HI01-1 through HI12-2 – Code List Qualifier Code	Use “BO” (CPT-4 or HCPCS code).
160	2000F – Service Level	HI – Procedures	HI01-3 through HI12-3 – Date Time Period Format Qualifier	Use “RD8” (Format CCYYMMDD-CCYYMMDD)

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
160	2000F – Service Level	HI – Procedures	HI01-4 through HI12-4 – Procedure Date	Specify the start date and end date of use.
180	2000F – Service Level	CRC – Patient Condition Information		Use this segment to provide any additional information regarding the patient's condition.
200	2000F – Service Level	CR5 – Home Oxygen Therapy Information	CR507 – Daily Oxygen Use Count	MDCH requires the reporting of the daily oxygen use count.
203	2000F – Service Level	CR5 – Home Oxygen Therapy Information	CR516 – Portable Oxygen System Flow Rate	MDCH requires the reporting of the oxygen system flow rate for portable oxygen systems.
211	2000F – Service Level	MSG – Message Text	MSG01 – Free-form Message Text	This data element is used to communicate procedure modifier information and to communicate additional service information not accommodated else where in the 278 Health Care Services Request transaction. Additional information is reported after procedure modifier information and is preceded by the word "TEXT". Refer to Appendix A for further information.
121	2000E – Service Provider Level	HL – Hierarchical Level		MDCH requires the communication of ordering provider information for oxygen service type. This is accommodated via a repeat of Loop 2000E, Loop 2010E, and their corresponding data elements. For further information regarding the transaction structure for identifying multiple providers, refer to page 31, Section 2.2.3.5, of the X12N 278 Version 4010 Implementation Guide.
125	2010E – Service Provider Name	NM1 – Service Provider Name	NM101 – Entity Identifier Code	Use "1T" (Physician, Clinic, or Group Practice).
127	2010E – Service Provider Name	REF – Service Provider Supplemental Identification	REF01 – Reference Identification Qualifier	Required by MDCH. Use "ZH" (Carrier Assigned Reference Number).
128	2010E – Service Provider Name	REF – Service Provider Supplemental Identification	REF02 – Service Provider Supplemental Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by the 7-digit provider identification number).
129	2010E – Service Provider Name	N3 – Requester Address	N301 – Requester Address Line	Specify the address that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
130	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N401 – Requester City Name	Specify the city name that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N402 – Requester State or Province Code	Specify the state or province code that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N403 – Requester Zip Code	Specify the zip code that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N404 – Requester Country Code	When the location that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E is not within the United States, specify the applicable country code (e.g., Canada).
134	2010E – Service Provider Name	PRV – Requester Provider Information	PRV01 – Provider Code	Required for use by MDCH when Loop 2000E is repeated. Use “OR” (Ordering).

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Physician Services Service Type

Submission of a 278 Health Care Services Request for these service types still requires the mailing of supporting documentation to the following address or via the noted fax number:

Medical Services Administration
Special Services-Prior authorization
PO Box 30170
Lansing, MI 48909

Fax number: 1-517-335-0075

The trace number submitted on the electronic request (Loop 2000C TRN02) must be noted on all mailed or faxed supporting documentation. This must be a unique number assigned to each individual patient/beneficiary prior authorization request. Failure to place the trace number on all mailed or faxed documentation may result in the rejection or denial of your prior authorization or preadmission certification request.

In addition to the following information, please refer to the 278 Request for Review Companion document – All Service Types section.

Page*	Loop	Segment	Data Element	Comments
141	2000F – Service Level	UM – Health Care Services Review Information	UM01 – Request Category Code	Use “HS” (Health Services Review).
142	2000F – Service Level	UM – Health Care Services Review Information	UM03 – Service Type Code	Use one of the following codes: “2” (Surgery) “40” (Oral Surgery)
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-1 – Facility Type Code	Identifies the type of facility where services will be performed. List the applicable place of service code used in 837P CLM05-1.
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-2 – Facility Code Qualifier	Use “B” (Place of Service code used in 837P CLM05-1).
159	2000F – Service Level	HI – Procedures	HI01-1 through HI12-2 – Code List Qualifier Code	Use “BO” (CPT-4 or HCPCS code).
160	2000F – Service Level	HI – Procedures	HI01-3 through HI12-3 – Date Time Period Format Qualifier	Use “D8” (Format CCYYMMDD).

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
160	2000F – Service Level	HI – Procedures	HI01-4 through HI12-4 – Procedure Date	Specify the proposed or scheduled surgery date.
180	2000F – Service Level	CRC – Patient Condition Information		Use this segment to provide any additional information regarding the patient's condition.
211	2000F – Service Level	MSG – Message Text	MSG01 – Free-form Message Text	This data element is used to communicate procedure modifier information and to communicate additional service information not accommodated else where in the 278 Health Care Services Request transaction. Additional information is reported after procedure modifier information and is preceded by the word "TEXT". Refer to Appendix A for further information.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Preadmission Certification (MPRO) Service Type

Submission of a 278 Health Care Services Request for these service types may still require the submission of supporting documentation. Please contact the Michigan Peer Review Organization (MPRO) for further information at 1-800-727-7223.

The trace number submitted on the electronic request (Loop 2000C TRN02) must be noted on all mailed or faxed supporting documentation. Failure to place the trace number on all mailed or faxed documentation may result in the rejection or denial of your preadmission certification request.

In addition to the following information, please reference the 278 Request for Review Companion document – All Service Types section.

Page*	Loop	Segment	Data Element	Comments
141	2000F – Service Level	UM – Health Care Services Review Information	UM01 – Request Category Code	Use “AR” (Admission Review).
142	2000F – Service Level	UM – Health Care Services Review Information	UM03 – Service Type Code	Use“48” (Hospital – Inpatient).
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-1 – Facility Type Code	Identifies the type of facility where services will be performed. Do not use when Service Type Code reflects a facility type (e.g., Hospital – Inpatient). Refer to Loop 2000F UM04-2 for code information.
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-2 – Facility Code Qualifier	If the claim for payment will be submitted in the 837I format or on a UB-92 form, use “A” (Uniform Billing Claim Form Bill Type) and list the first and second position of the Uniform Bill Type Code in UM04-1. If the claim for payment will be submitted in the 837P or on a HCFA1500, use “B” (Place of Service code used in 837P CLM05-1) and list the applicable place of service code in UM04-1.
155	2000F – Service Level	DTP – Admission Date	DTP03 – Proposed or Actual Admission Date	MPRO requires the reporting of the admission date.
156	2000F – Service Level	DTP – Admission Date	DTP03 – Proposed or Actual Discharge Date	When applicable specify the discharge date.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
157	2000F – Service Level	DTP – Admission Date	DTP03 – Proposed or Actual Surgery Date	When applicable specify the surgery date.
159	2000F – Service Level	HI – Procedures	HI01-1 through HI12-2 – Code List Qualifier Code	Use “ABR” (Revenue Code)[4].
189	2000F – Service Level	CL1 – Institutional Claim Code	CL101 – Admission Type Code	When applicable, specify the admission type code.

[4] Addenda added, refer to page 68 of the October 2002 Addenda.
*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Therapy Service Types

Submission of a 278 Health Care Services Request for these service types still requires the mailing of supporting documentation to the following address or via the noted fax number:

Medical Services Administration
Special Services-Prior authorization
PO Box 30170
Lansing, MI 48909

Fax number: 1-517-335-0075

The trace number submitted on the electronic request (Loop 2000C TRN02) must be noted on all mailed or faxed supporting documentation. Failure to place the trace number on all mailed or faxed documentation may result in the rejection or denial of your prior authorization or preadmission certification request.

The communication of procedure modifiers is not readily supported in the X12N 278 version 4010. Please refer to Appendix A for the Modifier Communication Guidelines.

In addition to the following information, please refer to the 278 Request for Review Companion document – All Service Types section.

Page*	Loop	Segment	Data Element	Comments
81	2000C – Subscriber Level	HI – Subscriber Diagnosis	HI01-4 through HI04-4 – Diagnosis Date	MDCH requires the reporting of the date of diagnosis for therapy services.
125	2010E – Service Provider Name	NM1 – Service Provider Name	NM101 – Entity Identifier Code	Use “1T” (Physician, Clinic, or Group Practice) to report the evaluating therapist/pathologist information or the ordering provider information.
127	2010E – Service Provider Name	REF – Service Provider Supplemental Identification	REF01 – Reference Identification Qualifier	Required by MDCH. Use “ZH” (Carrier Assigned Reference Number).
128	2010E – Service Provider Name	REF – Service Provider Supplemental Identification	REF02 – Service Provider Supplemental Identifier	Supply the evaluating therapists/pathologists license or certification number. When the preceding NM1 segment contains the ordering provider information, report the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by the 7-digit provider identification number)
129	2010E – Service Provider Name	N3 – Requester Address	N301 – Requester Address Line	Not applicable for evaluating therapist/pathologist. Specify the address that corresponds with the MDCH nine-digit ordering provider identifier submitted in REF02 of Loop 2010E.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
130	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N401 – Requester City Name	Not applicable for evaluating therapist/pathologist. Specify the city name that corresponds with the MDCH 9-digit ordering provider identifier submitted in REF02 of Loop 2010E.
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N402 – Requester State or Province Code	Not applicable for evaluating therapist/pathologist. Specify the state or province code that corresponds with the MDCH 9-digit ordering provider identifier submitted in REF02 of Loop 2010E.
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N403 – Requester Zip Code	Not applicable for evaluating therapist/pathologist. Specify the zip code that corresponds with the MDCH 9-digit ordering provider identifier submitted in REF02 of Loop 2010E.
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N404 – Requester Country Code	Not applicable for evaluating therapist/pathologist. When the location that corresponds with the MDCH nine-digit ordering provider identifier submitted in REF02 of Loop 2010E is not within the United States, specify the applicable country code (e.g., Canada).
134	2010E – Service Provider Name	PRV – Requester Provider Information	PRV01 – Provider Code	Required for use by MDCH. Use “OT” (Other Physician) for evaluating therapist/pathologist. Use “OR” (Ordering) for ordering provider.
141	2000F – Service Level	UM – Health Care Services Review Information	UM01 – Request Category Code	Use “HS” (Health Services Review).
142	2000F – Service Level	UM – Health Care Services Review Information	UM03 – Service Type Code	Use one of the applicable codes: “AD” (Occupational Therapy) “AE” (Physical Medicine) “AF” (Speech Therapy)
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-1 – Facility Type Code	Identifies the type of facility where services will be performed. Refer to Loop 2000F UM04-2 for code information.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
146	2000F – Service Level	UM – Health Care Services Review Information	UM04-2 – Facility Code Qualifier	If the claim for payment will be submitted in the 837I format or on a UB-92 form, use "A" (Uniform Billing Claim Form Bill Type) and list the first and second position of the Uniform Bill Type Code in UM04-1. If the claim for payment will be submitted in the 837P or on a HCFA1500, use "B" (Place of Service code used in 837P CLM05-1) and list the applicable place of service code in UM04-1.
155	2000F – Service Level	DTP – Admission Date	DTP03 – Proposed or Actual Admission Date	When applicable, supply the admission date.
159	2000F – Service Level	HI – Procedures	HI01-1 through HI12-2 – Code List Qualifier Code	Use "BO" (CPT-4 or HCPCS code), or Use "ABR" (Revenue Code)[5].
160	2000F – Service Level	HI – Procedures	HI01-6 through HI12-6 – Procedure Quantity	Supply the Number Per Month.
175	2000F – Service Level	HSD – Health Care Services Delivery		MDCH requires the use of the HSD segment to communicate the pattern of delivery, duration of need, and/or usage information needed to process these service type requests.
180	2000F – Service Level	CRC – Patient Condition Information		Use this segment to provide any additional information regarding the patient's condition.
211	2000F – Service Level	MSG – Message Text	MSG01 – Free-form Message Text	This data element is used to communicate procedure modifier information and to communicate additional service information not accommodated else where in the 278 Health Care Services Request transaction (e.g., Goals, progress note, or discharge plan). Additional information is reported after procedure modifier information and is preceded by the word "TEXT". Refer to Appendix A for further information.
121	2000E – Service Provider Level	HL – Hierarchical Level		When therapist/pathologist information is reported in the initial 2010E loop, a repeat of Loop 2000E, Loop 2010E, and their corresponding data elements is necessary to communicate the ordering provider information. For further information regarding the transaction structure for identifying multiple providers, refer to page 31, Section 2.2.3.5, of the X12N 278 Version 4010 Implementation Guide.

[5] Addenda added, refer to page 68 of the October 2002 Addenda.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
125	2010E – Service Provider Name	NM1 – Service Provider Name	NM101 – Entity Identifier Code	Use “1T” (Physician, Clinic, or Group Practice).
127	2010E – Service Provider Name	REF – Service Provider Supplemental Identification	REF01 – Reference Identification Qualifier	Required by MDCH. Use “ZH” (Carrier Assigned Reference Number),
128	2010E – Service Provider Name	REF – Service Provider Supplemental Identification	REF02 – Service Provider Supplemental Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by the 7-digit provider identification number)
129	2010E – Service Provider Name	N3 – Requester Address	N301 – Requester Address Line	Specify the address that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.
130	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N401 – Requester City Name	Specify the city name that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N402 – Requester State or Province Code	Specify the state or province code that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N403 – Requester Zip Code	Specify the zip code that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E.
131	2010E – Service Provider Name	N4 – Requester City/State/Zip Code	N404 – Requester Country Code	When the location that corresponds with the MDCH 9-digit provider identifier submitted in REF02 of Loop 2010E is not within the United States, specify the applicable country code (e.g., Canada).
134	2010E – Service Provider Name	PRV – Requester Provider Information	PRV01 – Provider Code	Required for use by MDCH when Loop 2000E is repeated. Use “OR” (Ordering).

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

278 Response Transaction Data Elements

Page*	Loop	Segment	Data Element	Comments
226	2010A – Utilization Management Organization (UMO) Name	NM1 – Utilization Management Organization (UMO) Name	NM108 – Identification Code Qualifier	"PI" (Payer ID) for MDCH prior authorization requests or "24" (Employer Identification Number) for MPRO preadmission certification requests.
227	2010A – Utilization Management Organization (UMO) Name	NM1 – Utilization Management Organization (UMO) Name	NM109 – UMO Identifier	"D00111" for MDCH or "'382536610" for MPRO.
230	2010A – Utilization Management Organization (UMO) Name	AAA – UMO Request Validation	AAA03 – Reject Reason Code	Refer to the Transaction Rejection Explanation section of this document.
240	2010B – Requester Name	REF – Requester Supplemental Identification	REF01 – Reference Identification Qualifier	Use "ZH" (Carrier Assigned Reference Number).
240	2010B – Requester Name	REF – Requester Supplemental Identification	REF02 – Requester Supplemental Identifier	Reflects the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by the 7-digit provider identification number).
241	2010B – Requester Name	AAA – Requester Request Validation	AAA03 – Reject Reason Code	Refer to the Transaction Rejection Explanation section of this document.
247	2000C – Subscriber Level	AAA – Subscriber Request Validation	AAA03 – Reject Reason Code	Refer to the Transaction Rejection Explanation section of this document.
253	2000C – Subscriber Level	HI – Subscriber Diagnosis	HI01-2, HI02-2, HI03-2 and HI04-2 – Diagnosis Code	When prior authorization or preadmission certification requests are approved or denied, the ICD-9-CM codes used to make the decision will be returned.
127*	2000C – Subscriber Level	PWK – Additional Patient Information	PWK02 – Attachment Transmission Code	When requesting additional beneficiary (patient) information, MDCH will use one of the following: "BM" (By Mail) "FX" (By Fax)
127*	2000C – Subscriber Level	PWK – Additional Patient Information	PWK06 – Attachment Control Number	MDCH will report the same number reflected as the Patient Event Tracking Number in Loop 2000C TRN02 of the 278 Request.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
263	2010CA – Subscriber Name	NM1 – Subscriber Name	NM108 – Subscriber ID Code Qualifier	Use “MI” (Member ID = Recipient ID).
263	2010CA – Subscriber Name	NM1 – Subscriber Name	NM109 – Subscriber Identifier	Reflects the MDCH recipient 8-digit identification number submitted on the 278 Request.
267	2010CA – Subscriber Name	AAA – Subscriber Request Validation	AAA03 – Reject Reason Code	Refer to the Transaction Rejection Explanation section of this document.
307	2010E – Service Provider Name	REF – Service Provider Supplemental Identification	REF01 – Reference Identification Qualifier	Use “ZH” (Carrier Assigned Reference Number).
307	2010E – Service Provider Name	REF – Service Provider Supplemental Identification	REF02 – Service Provider Supplemental Identifier	Reflects the 9-digit provider identifier assigned by MDCH (two-digit provider type followed by the seven-digit provider identification number)
314	2010E – Service Provider Name	AAA – Service Provider Request Validation	AAA03 – Reject Reason Code	Refer to the Transaction Rejection Explanation section of this document.
323	2000F – Service Level	AAA – Service Request Validation	AAA03 – Reject Reason Code	Refer to the Transaction Rejection Explanation section of this document.
325	2000F – Service Level	UM – Health Care Services Review Information	UM01 – Request Category Code	Use “AR” (Admission Review) for MPRO preadmission certification requests. Use “HS” (Health Services Review) for MDCH prior authorization requests.
326	2000F – Service Level	UM – Health Care Services Review Information	UM02 – Certification Type Code	Use one of the following applicable codes: “I” (Initial) “4” (Extension) "R” (Renewal) “S” (Revised)

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Page*	Loop	Segment	Data Element	Comments
331	2000F – Service Level	HCR – Health Care Services Review	HCR01 – Certification Action Code	Use one of the following applicable codes: "A1" (Certified In Total/Approved) "A3" (Not Certified/Denied) "A4" (Pended) "A6" (Modified/Approved) "CT" (Contact Payer)
346	2000F – Service Level	HI – Procedures	HI01-1 through HI12-2 – Code List Qualifier Code	Use one of the following applicable codes: "BO" (CPT-4 or HCPCS code) "BQ" (ICD-9-CM Procedure code) "JP" (ADA/CDT code) "ABR" (Revenue Code)[6]
218*	2000F – Service Level	PWK – Additional Service Information	PWK02 – Attachment Transmission Code	When requesting additional service information, MDCH will use one of the following: "BM" (By Mail) "FX" (By Fax)
382	2000F – Service Level	PWK – Additional Service Information	PWK06 – Attachment Control Number	MDCH will report the same number reflected as the Patient Event Tracking Number in Loop 2000C TRN02 of the 278 Request.
383	2000F – Service Level	MSG – Message Text	MSG01 – Free-form Message Text	MDCH will use this data element to communicate procedure modifier information, tooth number and tooth surface information and to communicate additional service information not accommodated elsewhere in the 278 Health Care Services Request transaction. Additional information is reported after procedure modifier information and is preceded by the word "TEXT". Refer to Appendix A and B for further information.

[6] Addenda added, refer to page 195 of the October 2002 Addenda.

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide (version 4010).

Transaction Rejection Explanation

When a 278 Health Care Service Request transaction is missing data needed to process the request or contains invalid data that interferes with the processing of the request, an AAA segment will be returned.

The following tables provide information about each AAA segment applicable to the MDCH or MPRO business process.

- **Loop 2010A – UMO Name AAA Segment**

278 Rejection Code and Description	Explanation	Requester Follow-up Action
04 Authorized Quantity Exceeded	Indicates that the transaction exceeds the maximum number of patient events. The implementation guide limits each transaction to a single patient event.	Break out individual prior authorization or preadmission certification requests into separate 278 Request transactions (ST through SE) and resubmit.
41 Authorization/Access Restrictions	The requester submitted the 278 Request transaction without identifying it as a Request (data element BHT02 is invalid.)	Update the BHT02 data element with the correct value (13) and resubmit the 278 Request transaction.
79 Invalid Participant Identification	The 278 Request transaction does not identify MDCH or MPRO correctly.	Update Loop 2010A NM109 data element with the correct information.
T4 Payer Name or Identifier Missing	The 278 Request is missing MDCH or is missing MDCH's payer ID or is missing MPRO or is missing MPRO's identifier.	Update Loop 2010A NM103 data element with Michigan Department of Community Health or MPRO or update NM109 with the correct corresponding identifier.
80 No Response Received – Transaction Terminated	A request for additional information was made and no further information has been received.	Requester will need to submit a new 278 Health Care Services Request for Review with the applicable prior authorization request information.

- **Loop 2010B – Requester AAA Segment**

278 Rejection Code and Description	Explanation	Requester Follow-up Action
41 Authorization/Access Restrictions	Requesting Entity is a free standing clinic.	Prior authorization request cannot be processed for free standing clinics.
43 Invalid/Missing Provider Identification	Service Bureau ID is invalid.	Correct and resubmit 278 Request.
44 Invalid/Missing Provider Name	Provider name does not match the supplied provider type and provider ID or is missing.	Correct and resubmit 278 Request.
45 Invalid/Missing Provider Specialty	Provider Role submitted and required taxonomy code was not submitted or is invalid.	Correct and resubmit 278 Request.
50 Provider Ineligible for Inquiries – Use if the provider is not authorized for requests.	Prior authorization request is from an unauthorized provider type.	Review submitted provider information. If an incorrect provider type was submitted, correct and resubmit 278 Request. If the provider type is correct, the prior authorization request cannot be processed for the requesting entity.
51 Provider Not on File	Requesting provider is not on file (end dated.)	Prior authorization request cannot be processed for requesting entity.
79 Invalid Participant Identification – Use for invalid/missing requester supplemental identifier.	MDCH provider ID is missing or invalid.	Correct and resubmit 278 Request.
97 Invalid or Missing Provider Address	Requesting entity address does not match the submitted Requesting provider ID or is missing some data.	Correct and resubmit 278 Request.

- **Loop 2000C – Subscriber AAA Segment**

278 Rejection Code and Description	Explanation	Requester Follow-up Action
15 Required application data missing – Use for missing diagnosis codes and dates.	ICD-9-CM (diagnosis) code(s) and/or dates to support the prior authorization or preadmission certification request are missing.	Correct and resubmit 278 Request.
33 Input Errors – Use for invalid diagnosis codes and dates.	ICD-9-CM code(s) and/or supporting dates are invalid.	Correct and resubmit 278 Request.
56 Inappropriate Date – Use when the type of date (Accident, Last Menstrual Period, Estimated Date of Birth, Onset of Current Symptoms or Illness) used on the request is inconsistent with the patient condition or services requested.		Correct and resubmit 278 Request.

- **Loop 2010CA – Subscriber Name AAA Segment**

278 Rejection Code and Description	Explanation	Requester Follow-up Action
58 Invalid/Missing Date-of-Birth	Date of birth is in an incorrect format or is invalid.	Correct and resubmit 278 Request.
64 Invalid/Missing Patient ID	Recipient ID is invalid or missing.	Correct and resubmit 278 Request.
65 Invalid/Missing Patient Name	Recipient name is missing or invalid.	Correct and resubmit 278 Request.
67 Patient Not Found	Recipient not found or coverage has been terminated.	Correct and resubmit 278 Request.
71 Patient Birth Date Does Not Match That for the Patient on the Database	Reported date of birth for the recipient does not match eligibility records for the reported recipient ID.	Correct and resubmit 278 Request.
95 Patient Not Eligible	Beneficiary coverage terminated.	Resubmission not allowed.

- **Loop 2010E – Servicing Provider AAA Segment**

278 Rejection Code and Description	Explanation	Requester Follow-up Action
43 Invalid/Missing Provider Identification	Service Bureau ID or Federal Tax ID is missing.	Correct and resubmit 278 Request.
44 Invalid/Missing Provider Name	Servicing provider name is missing or does not match the provider ID submitted.	Correct and resubmit 278 Request.
45 Invalid/Missing Provider Specialty	Provider Role submitted and the required taxonomy code was not submitted or is invalid.	Correct and resubmit 278 Request.
46 Invalid/Missing Provider Phone Number		Correct and resubmit 278 Request.
47 Invalid/Missing Provider State		Correct and resubmit 278 Request.
49 Provider Is Not Primary Care Physician		Correct and resubmit 278 Request.
51 Provider Not on File	The submitted servicing provider ID is not on file or has been end dated.	Request cannot be processed.
79 Invalid Participant Identification – Use for invalid/missing requester supplemental identifier.	MDCH provider ID is missing or invalid.	Correct and resubmit 278 Request.
97 Invalid or Missing Provider Address	Servicing provider address does not match the submitted provider ID or is missing some data.	Correct and resubmit 278 Request.

- **Loop 2000F – Service AAA Segment**

278 Rejection Code and Description	Explanation	Requester Follow-up Action
15 Required application data missing – Use when data is missing that is not covered by another Reject Reason Code; for example, use for missing procedure codes and procedure dates.	Procedure code qualifier or the applicable procedure code (CPT/HCPCS, ADA, ICD-9-CM, Revenue) is missing.	Correct and resubmit 278 Request.
33 Input Errors – Use for input errors in the service data not covered by the other reject reason codes listed; for example, use for invalid place of service codes and invalid procedure codes and procedure dates.	Submitted procedure date(s) are in an incorrect format or are invalid (e.g., 20030229).	Correct and resubmit 278 Request.
57 Invalid/Missing Date(s) of Service – Use for invalid/missing service, admission, surgery, or discharge dates.		Correct and resubmit 278 Request.
60 Date of Birth Follows Date(s) of Service		Correct and resubmit 278 Request.
T5 Certification Information Missing – Use to indicate missing previous certification number information.	Renewals and extension requests require the reporting of the previous prior authorization or PACE number.	Correct and resubmit 278 Request.

278 Request and 278 Response Transactions

Appendix A – Modifier Communication Guidelines

Modifier(s) is/are reported in addition to the CPT-4 or HCPCS procedure code to represent the specific details of a procedure properly. A payer may also use modifier(s) to determine the appropriate reimbursement level. MDCH, acting as a Medicaid payer, uses modifiers for these reasons.

The 278 (004010X094 and 004010X094A1) transactions do not contain data elements for reporting procedure code modifiers. MDCH has adopted the recommended National Medicaid Electronic data interchange HIPAA (NMEH) workgroup Procedure Code Modifier Workaround until these data elements are added to the 278 transactions.

To ensure that services submitted via the 278 Health Care Services Request are not rejected or denied due to insufficient information, providers can communicate up to four (4), two-position, procedure modifiers per procedure code via a fixed-length format in the MSG segment of Loop 2000F.

The communication of any additional service information not communicated through any other data elements within the 278 transactions is also accommodated in the MSG segment of Loop 2000F. The additional information is placed immediately following the modifier fixed length format (refer to Modifier Format Requirements.) This additional information must always be preceded by the word TEXT. Failure to use the word TEXT for this purpose could result in the rejection or denial of the 278 Health Care Services Request.

Modifier Format Requirements

Up to 12 procedures can be submitted for each 2000F loop via the HI segment. There can be up to four (4) modifiers per procedure reported to MDCH. The fixed-length format for each procedure will be a total of 12 positions. In the event that 12 procedures are reported in the HI segment of Loop 2000F and all 12 procedures have at least one (1) modifier, a total of 144 bytes (of the available 264 bytes) of Loop 2000F MSG01 data element would be used.

The first four (4) positions identify the Loop 2000F HI data element that corresponds to the modifiers following it. The eight (8) positions that follow the four (4) position HI data element is used for the four (4) two position modifiers. If the procedure has less than four (4) modifiers, the remaining positions are space-filled (e.g., “HI015076 ”).

If there is a need to communicate additional service information as a text message, begin the additional information with the word TEXT. This occurs regardless of modifiers being reported in the MSG segment (e.g., “HI015076 TEXT HERE IS SOME ADDITIONAL INFORMATION”).

This format will be used when applicable on the 278 Health Care Services Request and on the 278 Health Care Services Response. Examples of this format follow:

1. HI segment contains 12 procedures and all 12 procedures have at least one modifier. There is also a text message.

```
MSG*HI0152      HI025250    HI03762251  HI0426      HI05LT      HI0626
HI07TC      HI08TC      HI0952      HI1026      HI1152      HI1226
TEXT THIS IS AN EXAMPLE OF ADDITIONAL SERVICE INFORMATION.~
```

2. HI segment contains 12 procedures. Only the procedures submitted in HI02 and HI08 have modifiers.

```
MSG*HI02F177    HI08F277    ~
```

3. Procedures submitted do not require the submission of modifiers but there is additional service information that needs to be communicated.

```
MSG*TEXT ANOTHER EXAMPLE OF COMMUNICATING ADDITIONAL SERVICE
INFORMATION.~
```

Appendix B – Tooth Surface Code(s) Communication Guidelines

Up to 12 procedures can be submitted per each 2000F loop via the HI segment. When each dental procedure code requires the reporting of a tooth number, a maximum of six (6) dental procedure codes can be reported in the HI segment. For MDCH to be informed regarding the tooth number that corresponds with a dental procedure code, the tooth number should always be reported in the HI segment data element that follows the dental procedure code. An example follows:

```
HI*B0:D5110*JP:10~
```

When requesting prior authorization for dental services, the HI procedure segment of the 278 Request transaction should always begin with the dental procedure code (qualifier code “B0”) in the HI01-1 data element as noted in the above example.

Dental procedure codes do not identify the specific tooth surface applicable for the requested prior authorization. Without these code(s), the MDCH prior authorization process for dental services cannot be completed. The 278 (004010X094 and 004010X094A1) transactions do not contain data elements for these codes. MDCH is using a temporary solution until a data element that accommodates the communication of these codes is added to the 278 transactions.

Tooth Surface Code(s) Format Requirements

To ensure that dental services submitted via the 278 Health Care Services Request are not rejected or denied due to insufficient information, providers can communicate up to five (5) surface codes per dental procedure code via a fixed-length format in the MSG segment of Loop 2000F. The fixed-length format for each procedure will always be a total of 9 positions. In the event that 12 dental procedures are reported in the HI segment of Loop 2000F (and the services do not require the reporting of a tooth number), a total of 108 bytes (of the available 264 bytes) of Loop 2000F MSG01 data element would be used.

The first four (4) positions identify the Loop 2000F HI data element of the corresponding dental procedure code. The five (5) positions that follow the HI data element are allocated for the corresponding tooth surface code(s). If the procedure has fewer than five (5) tooth surfaces, the remaining positions are space-filled (e.g., “HI01IAM ”).

The MSG segment of Loop 2000F can also accommodate the communication of additional service information. Additional service information is placed immediately following the tooth surface codes fixed-length format and must always be preceded by the word “TEXT”. This occurs regardless of tooth information being reported in the MSG segment (e.g., “MSG*TEXT HERE IS SOME ADDITIONAL INFORMATION~”). Failure to use the word “TEXT” could result in the rejection or denial of the 278 Health Care Services Request. This format will be used on the 278 Health Care Services Request and on the 278 Health Care Services Response. Examples of this format follow.

1. HI segment contains 12 dental procedures and all 12 have at least one tooth surface. There is also a text message.

```
MSG*HI01IAF  HI02IAF  HI03A    HI04I    HI05HFB  HI06JDF  HI07BDA
HI08IAMOLHI09A    HI10B    HI11LAB  HI12KAB  TEXT THIS IS AN EXAMPLE
OF ADDITIONAL DENTAL SERVICE INFORMATION.~
```

2. HI segment contains three (3) dental procedures. All dental procedures submitted have tooth surface code(s). There is no text message.

   ```
   MSG*HI01AL    HI02FIALMHI03FIA~
   ```

3. Procedures submitted do not require the submission of a tooth surface code but there is additional service information that needs to be communicated.

   ```
   MSG*TEXT ANOTHER EXAMPLE OF COMMUNICATING ADDITIONAL SERVICE
   INFORMATION.~
   ```